FACE INVESTIGATION

SUBJECT: Service worker for alarm system company dies after 35 foot fall

SUMMARY:

A 24 year old white male service worker who had worked 3 1/2 years for his employer fell 35 feet sideways onto a concrete floor from an aluminum ladder placed against a steel I beam. The worker was responding to a complant regarding a faulty alarm system. A Witnesses, not co-workers, held the ladder while the worker went up to check to alarm placed on the ceiling of a garage. The witnesses heard the worker yell after he reached the alarm located on the ceiling, then saw him fall sideways striking his head and shoulder on the concrete. The victim died within 1 hour despite immediate rescue assistance and conveyance to a local hospital. The Wisconsin FACE investigator concluded that, in order to prevent similar occurrances, the employer should:

! Develop, implement and enforce a written comprehensive safety program that includes but is not limited to training in fall hazard recognition and electrical hazard recognition.

! Establish implement and enforce a written safety program consisting of energy control procedures and employee training for lockout and tagout.

! Provide non conductive ladders and specific rules regarding the use of ladders.
! Provide the worker with lockout hardware, locks, chains, wedges, key locks, adapter pins, self-locking fasteners, or other hardware to lock out energy sources.

INTRODUCTION:

At 1:20 PM on July 14, 1992, a 24 year old service representative for a security alarm business fell 15-20 feet from a ladder to a cement floor. The Wisconsin FACE investigator was notified by the Department of Industry Labor and Human Relations on July 22, 1992. A visit was made to the site on August 12, 1992 along with a safety inspector from the Wisconsin Department of Industry Labor and Human Relations. The employer refused an interview. The site of the incident was a county garage, a site visit was made and two persons who witnessed the incident were interviewed. A death certificate, police report, coroners report, workers compensation report and an OSHA report were obtained.

The employer has been in business for 11 years and employs a safety officer. There are over 2,000 employees in the national wide company. The victim had worked at the company 3 years and 6 months. The OSHA report indicated that there were no written lockout tag out or ladder safety training or rules. A company representatives spoke to the FACE investigator briefly by phone and did not wish to comment on safety rules and training issues. time of the incident.

INVESTIGATION:

On the morning of July 14, 1992 a service technician was called to a county garage to evaluate an alarm system that had gone off for no apparent reason. The worker arrived at the site alone and used a 20-40 foot aluminum extension ladder that he borrowed from the county weatherization program at the site to access the alarms. He sucessfully climbed the ladder and checked the first alarm with 2 persons who were at the site holding the ladder. The victim then placed the ladder on a steel rafter to access the second ceiling alarm, this alarm was on the ceiling and cars were parked below. The ladder was placed at an angle far less that the required sharp angle rthe first alarm.

It is not clear if the victim pinched himself, received a shock, or fell for another reason. The ladder had rubber corrugated rail pads.

CAUSE OF DEATH: Subarachnoid hemorrage and bilateral basilar skull fracture.

RECOMMENDATIONS/DISCUSSION:

Recommendations: Design the placement of the security alarm system and maintenance of the system with placement done from below.

Other recommendations: Strict adherence to OSHA lock out tag out requirements. The worker was reaching over wires that energize a rail crane to reach the ceiling alarm system. The power had not been shut off according to witnesses. Workers require training in hazard recognition, lockout tagout, and ladder safety in accordance with current OSHA standards. Strict adherence to OSHA ladder safety requirements.